Dietrich School District No. 314

3510F(2)
STUDENTS

Authorization for Self-Administered Medication

Student's Name: _____ Grade: _____ DOB: _____

Parent/Guardian Name: _____

Telephone: (Home): _____ (Work): _____

I give my permission for my child to self-administer the medication described below. I shall indemnify and hold harmless the District and its employees or agents for legal fees, costs, and any potential damages concerning self-administration of this medication arising out of any claims brought by the above named child or anyone else.

……...…….

THE FOLLOWING IS TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I am giving consent that the above named student be allowed to self-administer the following medication.

Name and Purpose of Medication: _____

Identification of Chronic Medical Problem: _____

_____

Dosage to be taken: _____

Length of Time Medication can be taken: _____

Conditions under which self-medication will take place: (please initial)

_____ Under the supervision of an office staff member

_____ Medication will be stored in the office

_____ _____

Print Parent/Guardian's Name Parent/Guardian's Signature

_____

Date